

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031811

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 99

Primary Registration District No. 5377

Registrar's No. 43

FILED SEP 10 1963

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairport.		Length of stay in Tb Life	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Family Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Flora Belle Halter		4. DATE OF DEATH Month Day Year 8 9 63	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-21-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Mo
13a. FATHER'S NAME Thomas Pearl		13b. MOTHER'S MAIDEN NAME Kathryn Pearl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) no		17. INFORMANT John Halter	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Hypostatic pneumonia DUE TO (b). Carcinomatosis DUE TO (c). Carcinoma of scalp PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		12. CITIZEN OF WHAT COUNTRY U.S.A. 14. NAME OF HUSBAND OR WIFE none 16. SOCIAL SECURITY NO. Address Fairport Mo. INTERVAL BETWEEN ONSET AND DEATH 2-3 days ? ?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from June 1963 to August 9 1963 and last saw him alive on 8-9-63 Death occurred at 11.30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) J. S. Swartz M.D. 22b. ADDRESS Maysville, Mo. 22c. DATE SIGNED 9-2-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-12-63	23c. NAME OF CEMETERY OR CREMATORY Fairport	23d. LOCATION (City, town, or county) Fairport Mo
24. FUNERAL DIRECTOR John Brown		25. DATE RECD. BY LOCAL REG. 9-3-1963	
26. REGISTRAR'S SIGNATURE Lertie E. Davidson			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3935

P. O. Address Waysville, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.